**The Department of Social and Health Services, Medical Assistance Administration did not provide the State Auditor's Office with timely records and access to other sources of information needed to audit of payments for certain types of procedures.**

## Background

While performing work in other areas of the Medicaid audit, we found charges for treatments and procedures that did not appear to comply with the State Medicaid Plan's descriptions of allowable types of service. Specifically, we found payments for treatments that appeared to be unallowable or that required pre-authorization. The Medical Assistance Administration's Division of Medical Management has medical consultants who may have authorized these procedures. We expanded our scope to determine the significance of the transactions and to determine if the procedures had received prior approvals from the Division.

## Description of Condition

In the Department's records for the period January 1, 2003 through December 31, 2003, we found clients who appeared to have received elective surgical procedures for purposes other than remedying health conditions. Diagnostic and procedure codes on the providers' claims for reimbursement indicated these procedures included cosmetic and other elective surgeries that might not be allowable with Medicaid funds or that would require pre-authorization. The cost of the doubtful procedures we identified was $182,207. Because the related costs of these types of procedures for an individual client can occur over a period of more than one year, the total cost for them is unknown.

We performed our review with the information that was available to us. We encountered difficulties in obtaining information, as follows:

- We were not provided with access to line staff at the Division of Medical Management and were thus unable to obtain information from the consultants to help us determine what controls, if any, existed in this area or to help us determine if the procedures were truly unallowable.

- We did not receive documentation of requests for prior medical authorizations in a timely manner. During our previous audit, we had received these immediately after our request. This year, the Administration first stated it had no prior authorizations for the twelve specific clients whose medical approvals we had requested. Three weeks later, after our fieldwork ended, the Administration provided five of the authorizations they had earlier stated did not exist. This

series of events, along with the problems described above, significantly impaired the reliability of the documents for audit evidence.

**Cause of Condition**

The liaison system the Administration set up this year prevented us from obtaining the information and conducting the procedures necessary to complete our audit according to Generally Accepted Auditing Standards and in compliance with federal auditing regulations.

**Effect of Condition**

Because of an agency-imposed scope limitation, the State Auditor's Office did not have access to resources that would have allowed us to assess controls and to independently evaluate whether the Department was complying with Medicaid requirements in this area. Therefore, we cannot provide an opinion on compliance regarding allowable costs and eligibility of clients for Medicaid claims paid for types of services that appear to be unallowable.

**Recommendations**

With respect to compliance with audit requirements, we recommend the Department:

- Ensure that the State Auditor's Office has timely access to the information and resources it needs to complete its audit.

- Ensure managers understand the role of independent audits in reporting on compliance with applicable laws and regulations when a provision of continued receipt of those funds is contingent on compliance.

- Work with the U.S. Department of Health and Human Services to determine if any costs charged to Medicaid federal funds must be reimbursed as a result of this disclaimer.

**Department's Response**

The Department does not concur with this finding.

- The SAO's identification of doubtful procedures or diagnoses that may not be allowable for payment with Medicaid funds was based on a vague request for information regarding prior authorization for 12 clients. It was sent to MAA for review without explanation or without being linked to a specific audit. Since the auditor did not review detailed records, agency staff randomly sampled 12% of the total questioned claims and found that all payments were supported by documentation as evidence of

allowability, with the exception of one claim line amounting to $4.70. (Documentation of this review is available upon request).

- The Department also disagrees with the auditor's assertion that DSHS "…did not provide SAO with timely records and access to line staffs…". On the contrary, the Department made every attempt to be responsive and timely despite the vague data request and generally poor communications. The Department created a liaison system to improve these communications, but the procedures were often ignored and circumvented by auditors.

- This audit area is an excellent example of problems that could have been avoided with better communications and trust. It may assist both SAO and DSHS as they work to bridge these gaps during future audits.

**Auditor's Concluding Remarks**

**Applicable Laws and Regulations**

RCW 43.09.310 states in part:

> ...The state auditor shall annually audit the statewide combined financial statements prepared by the office of financial management and make post-audits of state agencies. Post-audits of state agencies shall be made at such periodic intervals as is determined by the state auditor....

The American Institute of Certified Public Accountants, Statement of Position 98-3, *Audits of States, Local Governments, and Not-for-Profit Organizations Receiving Federal Awards*, Paragraph 10.43 and 10.44 states, in part:

> The auditor is able to express on an unqualified opinion only if he or she has been able to apply all the procedures the auditor considers necessary in the circumstances. Restrictions on the scope of the audit - whether imposed by the client or by circumstances such as the timing of the auditor's work, an inability to obtain sufficient competent evidential matter, or an inadequacy of the accounting records - may require auditors to qualify their opinion or to disclaim an opinion.
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> When restrictions that significantly limit the scope of the audit are imposed by the client, the auditor generally should disclaim an opinion on compliance.

Title 42 of the Code of Federal Regulations, Section 430.10 describes the authority of the state Medicaid plan.

> The State plan is a comprehensive written statement submitted by the agency describing the nature and scope of its Medicaid program and giving assurance that it will be administered in conformity with the specific requirements of title XIX, the regulations in this Chapter IV, and other applicable official issuances of the Department. The State plan contains all information necessary for CMS to determine whether the plan can be approved to serve as a basis for Federal financial participation (FFP) in the State program.

The Department acknowledges the authority of the State Plan and states its commitment to abide by it in section 1.1 of the State Plan:

> As a condition for receipt of Federal funds under title XIX of the Social Security Act, the Department of Social and Health Services submits the following State plan for the medical assistance program, and hereby agrees to administer the program in accordance with the provisions of this State plan, the requirements of titles XI and XIX of the Act, and all applicable Federal regulations and other official issuances of the Department.

The State Plan, Attachment 3.1-B, Section 5.a. describes limitations on physicians' services, whether furnished in the office, the patient's home, a hospital, a nursing facility, or elsewhere. Subsection (1) includes as one of the limitations:

> Prior approval of non-emergent surgery and/or non-emergent hospital admission.